BQC - 91 – 003

Date: February 11, 1991

To: Nursing Homes NH 2

From: Larry Tainter, Director
Bureau of Quality Assurance

Subject: OBRA 1990 Revisions to OBRA 1987, and recent updates from HCFA

This is to inform you of certain revisions made to the Medicare and Medicaid nursing home provisions of the Social Security Act by the Omnibus Budget Reconciliation Act (OBRA) of 1990. These changes affect all nursing homes participating in the Medicare and Medicaid programs; they do not apply to licensed only homes. A package of technical amendments to the OBRA 1987 nursing home provisions were included in the bill, Public Law 101-508 enacted November 5, 1990. Changes relating to Nurse Aide Training/Nurse Aide Registry, and resident assessments were sent out earlier in other Bureau of Quality Compliance (BQC) memos.

1. Limitation on Charges: Facilities cannot charge residents more than the daily Medicaid rate if the residents meet state Medicaid eligibility requirements but are not receiving Medical Assistance (M.A.) reimbursement for nursing home coverage because their monthly income exceeds the Medicaid rate.

2. Access to Records: The law changes the time period in which residents or their legal representatives are to be given access to their current clinical records to within 24 hours (excluding weekends and holidays), instead of 48 hours.

3. Ombudsman Coordination: States are required to notify the state ombudsman of adverse actions taken against a nursing facility.

4. Nurse Staffing Waivers: The Medicaid licensed nursing staffing waiver is modified to allow states to waive both LPN and RN coverage "to the extent that a facility is unable to meet the requirements." Under both Medicare and Medicaid, the Health Care Financing Administration (HCFA) and the states must notify the state ombudsman and the state protection and advocacy system when they grant a waiver. When facilities receive a waiver, they must notify residents, or their legal representatives and members of residents' immediate families.

We have also received new information from HCFA on several issues, as follows:

5. Nurse Staffing Waivers: We have received directions from HCFA for handling nurse staff waivers in Medicaid certified facilities indicating that the requirement at 42 CFR 483.30(c) for nursing facilities (NFs) means that the state agency must conduct a survey to determine whether the health, safety and welfare of patients will not be affected by grating a nurse staffing waiver to a nursing facility. Therefore, the BQC will, for the most part, make a decision of NF staffing waivers at the time of the facility's annual survey.

   Nurse staff waiver of 483.30(d) for Medicare certified units/facilities will be reviewed and approved by HCFA.

6. Adequacy of Nurse Staffing: A recent HCFA program letter (#91-03) on nurse staffing requirements, particularly in Medicare distinct parts, is attached for your information. This resolves an issue that was addressed in an earlier BQC memo (90-090). HCFA's direction is that nursing staff can be shared across distinct parts, providing the facility as a whole has adequate staff.

7. Physician Visits (483.40): Physicians must visit all residents every 30 days for the first 90 days upon admission to a nursing home. In all Medicare certified SNFs, whether full facility or distinct part, the physician must visit residents at least once very 60 days after the first 90 days. For facilities or units which are Medicaid certified (NFs) only, the physician must visit residents at least once every 90 days after the first 90 days.

   The 60 and 90 day physician visits requirements are based on the location of the resident and the certification of this location in our facility; they are not based on payment source. The old requirement for visits every 30 days for individuals receiving specific therapies or treatments has been removed from the current regulations.

   In the past, federal regulations required that a schedule of alternate physician visits be approved by the Utilization Review (U.R.) committee and a copy of the schedule be sent to the state agency. This is not required under current federal regulations.

8. CLIA Lab Regulations: The long term care regulations at 42 CFR 483.75(1) establish a Level B requirement for laboratory services. We have been advised by HCFA that although this regulation is currently in effect, they will not be directing us to review this area in surveys until their new lab regulations are in effect. Currently, HCFA is drafting laboratory regulations in response to the Clinical Laboratory Improvement Act (CLIA) of 1988. Proposed regulations were published in 1990, and HCFA is reviewing the 40,000 plus comments from the public on these regulations. When they are published in final form, we expect to begin surveying clinical labs in all settings, including nursing homes.

   HCFA has further advised state agencies to remind nursing facilities that they will be surveyed against these laboratory requirements in the future and consequently should be developing laboratory arrangements with laboratory providers that will meet these requirements.

9. Plans of Correction (POCs) for Federal Deficiencies: A nursing home cannot be certified without an acceptable POC for each federal deficiency that is cited during any survey or investigation.

   The nursing home's POC must indicate when correction will be completed (date specific), what will be done to correct the deficiency, and who will monitor correction to ensure it will not recur.

   If a nursing home submits a POC that is not acceptable, the surveyor will call the facility to request an amendment to the POC so that it is acceptable. If this cannot be expeditiously accomplished, our surveyors have been instructed to process the survey report indicating the POC is not acceptable, and that the nursing home cannot be recertified. Based on this, termination action will be initiated on the nursing home's provider agreement.

   In addition to the above, HCFA has directed that deficiencies generally must be corrected within 60 days of notice. Because of this , surveyors have been instructed not to accept a time frame for correction of more than 60 days except in very unusual circumstances, such as deficiencies which will necessitate substantial capital expenditure (i.e., physical plant changes). We expect most plans of correction to show a completion date of not more than 45 days.

BQC acceptance of a plan of correction does not bind the Bureau of Health Care Financing (BHCF) to approving a rate adjustment under Medical Assistance. If you wish BHCF to consider adjusting reimbursement due to the plan of correction, please send a copy of the Statement of Deficiency (SOD) form 2567 along with your request to the appropriate regional BHCF auditor.

If you have any questions regarding these issues, please contact the appropriate Field Operations Manager for your facility.

LT/MJS/CAR/jh 5407

cc: -Susan Wood
-George F. MacKenzie
-Wisc. Assoc. of Nursing Homes
-Wisc. Assoc. of Homes/Services of the Aged
-Wisc. Counties Association
-Wis. Medical Records Assoc. Consultants Committee
-Service Employees International Union
-Wis. Coalition for Advocacy
-Board on Aging and Long Term Care
-Committee on Aging, Extended Care Facilities
-Wis. Assoc. of Medical Directors
-Director, Bureau of Health Care Financing
-Division of Care & Treatment Facilities
-HCFA, Region V